Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

LONGVIEW OCCUPATIONAL MEDICINE CLINIC
3202 NORTH 4TH SUITE 100
LONGVIEW TEXAS 75605

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-11-4745-01

MFDR Date Received
July 22, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "TWCC rule 180.22 requires WC pt to have a treating MD. The pt was seen on 3-18-11 to establish the WC contract & to check the wound & was seen again on 3-22-11 to check for problems. ER doctors do not do WC & do not do follow ups."

Amount in Dispute: $370.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The above reference medical fee dispute is due to the denial of payment for procedure code 99204 and procedure code 99214. After reviewing the provided documentation, the Carrier will reimburse the Provider for procedure code 99204. Payment was issued on August 29, 2011 in the amount of $225.00. After further review, the Carrier will not reimburse for Procedure code 99214. The documentation does not support the level of service billed."

Response Submitted by: Chartis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 18, 2011 and March 22, 2011	99204 and 99214	$370.00	$159.43

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline procedures for professional medical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 1 – No reduction available
   - 4 – A charge was made for a visit on the same day as a surgical procedure, or within the 10 day follow up of a previously performed surgery
   - 1 – Processed based on multiple or concurrent procedure rules
   - 2 – Payer deems the information submitted does not support this level of service
   - 5 – Documentation does not support level of service billed

Issues

1. Did the insurance carrier reimburse the requestor the MAR amount for CPT code 99204?
2. Did the requestor submit documentation to support the billing of CPT 99214?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Labor Code §134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

   The requestor disputes non-payment of CPT code 99204 rendered on March 18, 2011 in the amount of $225.00. The Medicare Physician Fee Schedule (MPFS) for CPT code 99204 is $153.96 with the application of the division conversion factor of $54.54, the total MAR is $247.14. The insurance carrier issued payment in the amount of $225.00 therefore, no additional reimbursement is recommended.
2. 28 Texas Administrative Code §134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The requestor disputes non-payment of CPT code 99214 rendered on March 22, 2011 in the amount of $145.00.

   The AMA CPT® Code's definition of CPT code 99214 is "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family."
3. Review of the office note dated March 22, 2011 documents 2 of the 3 components required for billing CPT code 99214. As a result, the requestor is entitled to reimbursement in the amount of $159.43.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $159.43.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $159.43 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		September 26, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.